MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08924

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elk Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs 2 mos.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elk Mills.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Barbara Ellen Aument

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Widow

6.(b) Name of husband or wife: George W. Aument

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan 14 1857.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
88.	9	2.		

9. Birthplace: York Co. Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: John Corbett

13. Birthplace: York Co Pa.

MOTHER — 14. Maiden name: Frances Alloway

15. Birthplace: York Co Pa.

16. Informant: Geo. W. Aument Jr.

Address: Elk Mills Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept-23-1945 (month) (day) (year)

Cemetery or crematory: Cherry Hill Cemetery

Location: Cherry Hill Md.

18. Funeral director: Florence E. Abernathy

Address: Elkton R. D. 5. Md.

19. Sept 21 1945 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16 1945, at 1045 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W. L. Dodson Jr. Medical Examiner Cecil County M. D. or other

Address: Rising Sun Md. Date signed 9-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

8925

★ Reg. Diat. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil Co
City or town: Near Elkton Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Near Elkton Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: RD 4
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Carheart Barnett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie May Barnett
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): February 7, 1886

8. AGE: Years	Months	Days	If less than one day
59	7	7	hrs. min.

9. Birthplace: Cecil Co, Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: William P Barnett
13. Birthplace: Cecil Co, Md
MOTHER 14. Maiden name: Mary E. Barnsley
15. Birthplace: Cecil Co. Md.
16. Informant: Florence E. Barnett
Address: Newark, Del.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16. 1945 (month) (day) (year)
Cemetery or crematory: Reed's Cemetery
Location: Near Elkton. Md.
18. Funeral director: J. E. Lyon
Address: Praying Sun. Md.
19. Sept 15 19 45 (Date rec'd by registrar) H B Fraze Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14 1945, at 3 00 A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1 1945 to Sept 14 1945
and that I last saw h[illegible] alive on Sept 14 1945

Immediate cause of death	DURATION
Congestive heart failure	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J B Robinson M.D.
M. D. or other
Address: Oxford Pa. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (b-a)

CERTIFICATE OF DEATH

08926

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Veterans Administration, Perry Point, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 3 mo. 21 da.
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Mass. County: Middlesex
City or town: West Newton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 Eddy Street
(If rural, give LOCATION)
2.(a) If veteran, name war: W.W. I

3. (a) FULL NAME: BEAL, Agnes G. (Mrs)

3. (b) Social Security Number: -

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or xxx Stanley Beal
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): Indefinite. Said to be 54.

8. AGE: Years: 54 | Months: - | Days: - | If less than one day: - hrs. - min.

9. Birthplace: Indiana
(Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business: -

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 9-10-45 (month) (day) (year)
Cemetery or crematory: Newton Cemetery
Location: Newton, Mass.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Sept. 10 19 45 (Date rec'd by registrar) Irma E. Dempsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 10 1945 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 20 1943, to September 10 1945
and that I last saw h. alive on September 10 1945

	DURATION
Immediate cause of death: Arteriosclerosis, general, cerebral and coronary	over 2 yrs 5 mo.
xxx Nephrosclerosis	Undetermined
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	Over 2 yr. 5 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op. -

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: J. E. Trollinger
A.E. TROLLINGER, Lt.Col. M.C. Clinical Director
Address: Veterans Administration, Perry Point, Md. Date signed: 9-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

08927

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton R D 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton R D 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Brady

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Lillian Brady
6.(c) If alive, give age: 78 years
7. Birth date of deceased (mo., day, yr.): No infomt 1865 ~ (79yrs)

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
80	-	-		

9. Birthplace: Warwick Cecil maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Richard Brady
FATHER 13. Birthplace: no information
MOTHER 14. Maiden name: no information
MOTHER 15. Birthplace: no information
16. Informant: Charles Brady
Address: Elkton Md R D 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 5 1945 (month) (day) (year)
Cemetery or crematory: Manor Cemetery
Location: Chesapeake City Md R D
18. Funeral director: H. W. Pippin
Address: Elkton Md
19. Sept 5 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 1st 1945 at 6.10 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 22 1945 to Sept 1st 1945
and that I last saw him alive on Sept 1 - 1945 ~
Immediate cause of death: Bronchial asthma
Due to: Allergic Reaction
Due to: General Arterio Sclerosis with general exhaustion
Other conditions:

DURATION
4 days
unknown

(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. H. Magee M. D. or other
Address: Elkton Md Date signed 9/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

08928

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

Reg. Dist. No. 95

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Cecil
City or town: Colora (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Colora (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Ella P. Burkins
3. (b) Social Security Number: 220-01-1773

4. Sex: F
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: John Burkins
6.(c) If alive, give age: 63 years
7. Birth date of deceased (mo., day, yr.): May 27, 1883

8. AGE:

Years	Months	Days	If less than one day
62	3	12	hrs. min.

9. Birthplace: Cecil Co., Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: At Home

FATHER
12. Name: Amos B. Gamble
13. Birthplace: Cecil Co. Md.

MOTHER
14. Maiden name: Mary A. Brown
15. Birthplace: Cecil Co., Md.

16. Informant: Mr. John Burkins
Address: Colora, Cecil Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 12 1945 (month) (day) (year)
Cemetery or crematory: Oxford Cem.
Location: Chester Co. Penna

18. Funeral director: H. S. Bailey
Address: Darlington, Md.

19. Sept. 10 1945 (Date rec'd by registrar) L. M. Worthington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9 1945, at 9 40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ......19...., to ......19.... and that I last saw h.... alive on ......19....

Immediate cause of death: Acute Coronary
Due to: Thrombosis
Due to:
Other conditions
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. C. Dodson M.D. Medical Examiner for Cecil County M. D. or other
Address: Rising Sun Md. Date signed 9-9-45

VS A15

(1)

Correct record Sept 9 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08929

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil

City or town Elkton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 36 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Elkton, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Andrew J. Cameron

3.(b) Social Security Number 212-14-1285

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Married

6.(b) Name of husband or wife Catherine Cameron

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1883

8. AGE: Years	Months	Days	If less than one day
62	10	6	....hrs. ....min.

9. Birthplace Ceilton (Town, county, and state)

10. Usual occupation Watchman

11. Industry or business

FATHER 12. Name Andrew J. Cameron

FATHER 13. Birthplace Snow Hill, Md

MOTHER 14. Maiden name No Information.

MOTHER 15. Birthplace

16. Informant Catherine Cameron

Address Elkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 29/45 (month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Md

18. Funeral director H. W. Pippin

Address Elkton, Md.

19. Sept 29 19 45 (Date rec'd by registrar) F R Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 - 19 45 at 6:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 - 19 19 Sept 26 19 45 and that I last saw h... alive on Sept 26 19 45

Immediate cause of death	DURATION
Coronary Occlusion	1 day
Due to Chronic myocarditis	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M.D. or other

Address Elkton Date signed Sept 29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09432

★ Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 8 mo. 23 da.

Hospital, Institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Ohio County: Mahoning

City or town: Youngstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 228 Livingston Street

(If rural, give LOCATION)

2.(a) If veteran, name war: Span. American ✓

3.(a) FULL NAME: CURRELL, John W.

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): 5-19-1878

8. AGE: Years	Months	Days	If less than one day
67	3	23	- hrs. - min.

9. Birthplace: Birkenshaw, England (Town, county, and atate)

10. Usual occupation: Mechanic

11. Industry or business: -

FATHER — 12. Name: John Currell

13. Birthplace: England

MOTHER — 14. Maiden name: Betty Benton

15. Birthplace: England

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9-13-1945 (month) (day) (year)

Cemetery or crematory: Todd Cemetary

Location: Youngstown, Ohio

18. Funeral director: Pennington & Son

Address: PENNINGTON & SON, Havre de Grace, Md.

19. Sept. 13 19 45 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 19 45 at 7:22 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 19 39, to September 11, 19 45

and that I last saw him alive on September 11, 45

Immediate cause of death	DURATION
Coronary Occlusion	Immediate
Due to: Arteriosclerosis, generalized	over 5 yrs.
Due to:	
Other conditions: Involutional Melancholia	over 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: 0 Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, Industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A. E. Trollinger

A. E. TROLLINGER, Lt. Col., M.C. Clinical Director

Address: Veterans Administration, Perry Point, Md.

Date signed: 9-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08930

Reg. Diat. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Elkton, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. High St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mollie E. Davis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	Married

6.(b) Name of husband or wife: George R. Davis

7. Birth date of deceased (mo., day, yr.): Dec 2 - 1884 6.(c) If alive, give age: 60 years

8. AGE:

Years	Months	Days	If less than one day
60	9	18	..... hrs. ..... min.

9. Birthplace: Newark Del (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: David Warren

FATHER — 13. Birthplace: Block Bird, Del

MOTHER — 14. Maiden name: Capitol Anderson

MOTHER — 15. Birthplace: Delaware

16. Informant: George R. Davis

Address: Elkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 23/45 (month) (day) (year)

Cemetery or crematory: Elkton,

Location: Elkton, Md

18. Funeral director: H. W. Pippin

Address: Elkton, Md.

19. Sept 22 19 45 (Date rec'd by registrar) E R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 20 19 45 at 4 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 19 45 to Sept 20 19 45 and that I last saw her alive on Sept 20 19 45

Immediate cause of death	DURATION
Carcinoma of breast	
right with fistulae	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of right breast

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Donald Spreeder M. D. M. D. or other

Address: Elkton, Md Date signed: Sept 22, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08931

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 236 W Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Howard Miller Deaner.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Stella Deaner

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Jan. 21 1889.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	8	29		

9. Birthplace: Cecil Co Md. (Town, county, and state)

10. Usual occupation: Mail Clerk.

11. Industry or business:

FATHER — 12. Name: Jos. Chas. Deaner.

13. Birthplace: Cecil Co Md.

MOTHER — 14. Maiden name: Susan Anderson

15. Birthplace: Cecil Co Md.

16. Informant: Mrs. Stella Deaner.

Address: 236 W. Main St Elkton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24 '45 (month) (day) (year)

Cemetery or crematory: Elm Hill Cemetery

Location: — Md.

18. Funeral director: Florence E Abernathy

Address: Elkton R. D. 5 Md.

19. Sept 21 1945 (Date rec'd by registrar) H B Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 20 1945 at 9406 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Cerebral Coronary Thrombosis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County M. D. or other

Address: Rising Sun Md. Date signed: 9-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

CERTIFICATE OF DEATH

08932

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs. 11 mos. 8 days

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? 18 yrs. 11 mos. 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: P.I. County:

City or town: Tibiao, Antique
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3. (a) FULL NAME: DELAMON, Ramon

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Filipino	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 17, 1893

8. AGE: Years	Months	Days	If less than one day
52	6	4	... hrs. ... min.

9. Birthplace: Tibiao, Antique, P.I. (Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business: Restaurant

FATHER
12. Name: Marcelino Delamon
13. Birthplace: Tibiao, Antique, P.I.

MOTHER
14. Maiden name: Natividad Gotieref
15. Birthplace: Tibiao, Antique, P.I.

16. Informant: Veterans Administration,
Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9-24-45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Pennington & Son
PENNINGTON & SON
Address: Havre de Grace, Md.

19. Sept. 24 1945 (Date rec'd by registrar) Irma E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21 19 45 at 3:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 13 19 26 to September 21 19 45 and that I last saw him alive on September 21 19 45

Immediate cause of death	DURATION
Carcinoma of Lungs & Liver	Undet.
Arteriosclerosis, general	Undet.
Due to: Dementia Praecox, Hebephrenic type	19 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: Carcinoma of Lungs & Liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: A. E. Trollinger

A. E. TROLLINGER, Lt.Col., M.C., Clinical Dir.

Address: VAF, Perry Point, Md. Date signed: 9-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
SEP 26 1945
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08933

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: VETERANS ADMINISTRATION, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months 12 days
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County: -
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3749 Jenifer St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: Boxer Rebellion

3.(a) FULL NAME: GOVER, Arthur

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: -
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): October 15, 1876

8. AGE: Years	Months	Days	If less than one day
68	10	26	- hrs. - min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Clark
11. Industry or business: -

FATHER
12. Name: Samuel A. Gover
13. Birthplace: Waterford, Va.

MOTHER
14. Maiden name: Teperance Matthews
15. Birthplace: Baltomore, County - Md.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 9-11-45 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Washington, D.C.
18. Funeral director: Pennington & Son
Address: Pennington & Son, Havre de Grace, Md.

19. Sept. 11, 1945 (Date rec'd by registrar) Irene E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 10, 1945, at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 29, 1945, to September 10, 1945, and that I last saw h... in alive on September 10, 1945.

Immediate cause of death	DURATION
Central Nervous System Lues-	
Meningo-Encephalitic type	Unknown
Due to: Myocardial insufficiency	
(cause syphilis)	Over 1 yr.
Due to	
Other conditions: Psychosis with Syphilis of	
the Central Nervous System	Approx. 9 mo

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op.: -
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: A.E. Trollinger
A.E. TROLLINGER, Lt.Col., M.C. M. D. or other
Address: Veterans Administration, Perry Point, Md. Date signed: 9-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

08934

Reg. Diat. No. 95

1. PLACE OF DEATH:

County: Cecil

City or town: Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Laura Jane Grason

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George R. Grason

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 8. 1863

8. AGE:

Years	Months	Days	If less than one day
82	8	14	..... hrs. ..... min.

9. Birthplace: Oxford Pa. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: Samuel Grason

13. Birthplace: Chrome, Pa.

MOTHER

14. Maiden name: Emma Cheny

15. Birthplace: Chrome Pa.

16. Informant: Vena Grason

Address: Rising Sun, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 25-1945 (month) (day) (year)

Cemetery or crematory: Brookview Cem.

Location: Rising Sun Md.

18. Funeral director: J. E. Tyson

Address: Rising Sun Md.

19. Sept 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-22 1945 at 9.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-18 1945 to 9-22 1945 and that I last saw h.. alive on 9/21 1945

Immediate cause of death	DURATION
Pneumonia	
Left side	
Due to	
Arterio sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: W. L. Woodcock M.D. M. D. or other

Address: Rising Sun Md. Date signed: 9-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs.
Hospital, institution, or street address where death occurred: Union Hospital, Elkton, Md.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 116 Bells Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Hamilton - James - A.

3.(b) Social Security Number: 204-07-7908

4. Sex: Male
5. Color or race: Blk
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Clara Hamilton
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): May 30 1906

8. AGE:

Years	Months	Days	If less than one day
40	3	26	... hrs. ... min.

9. Birthplace: Cecil Co Md
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: James A Hamilton Sr.
13. Birthplace: Warrick Md.

MOTHER
14. Maiden name: Elizabeth Owens
15. Birthplace: Cecil Co Md

16. Informant: Clara Hamilton
Address: 116 Bell's Lane Elkton, Md.

17. Burial (Burial, cremation, or removal. Which?)
Date thereof: Sept. 29, 1946 (month) (day) (year)
Cemetery or crematory: Providence Cemetry, Elkton
Location: Elkton, Md.

18. Funeral director: Edw R Bell
Address: 909 Poplar St. Wilm. Del.

19. Sept 28 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 26 - 1946, at 7:41 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21 - 1946, to Sept 26, 1946 and that I last saw him alive on Sept 23 - 46 19..

Immediate cause of death: Exhaustion - Colostomy
Due to: Carcinoma of Colon
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: 12 - 3 - 45 -
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: H. C. Cantwell Md
M. D. or other
Address: Sept 26 - 46
Date signed: 9/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

08935

Reg. Diat. No. 92

1. PLACE OF DEATH:
County Cecil Co.
City or town Elkton Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Union Hosp.
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Colora md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Baby Hamilton, Shirley Mae. | 3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept 22 1945

8. AGE: Years | Months | Days: 8 | If less than one day: ... hrs. ... min.

9. Birthplace Elkton Hospital (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Lee Hamilton
13. Birthplace Kentucky

MOTHER 14. Maiden name Essie Akers
15. Birthplace Kentucky

16. Informant Lee Hamilton
Address Colora md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-1-45 (month) (day) (year)
Cemetery or crematory Baptist
Location Conowingo md.

18. Funeral director J. E. Flynn
Address Rising Sun Md.

19. Oct 1 1945 F R Fraser
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1945 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/22 1945 to 9/29 1945 and that I last saw h... alive on 9/28-45 1945

Immediate cause of death	DURATION
Prematurity	
Due to Complications	
Due to Gestation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. H. Dodson M.D. M. D. or other
Address Rising Sun Md. Date signed 9/30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for the change of age is shown on [illegible] G 99 NOV 1 1945

08936

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:
County: Cecil
City or town: North East
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: North East
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: Not a veteran

3.(a) FULL NAME: Winter Isaacs

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Lewis Isaacs
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): April 2, 1868

8. AGE: Years	Months	Days	If less than one day
77	5	26	hrs. min.

9. Birthplace: North East, Cecil Co., Md.
(Town, county, and state)
10. Usual occupation: Trackman
11. Industry or business: Penna. R. R.
FATHER 12. Name: Carey Isaacs
FATHER 13. Birthplace: Bucks Co. Penna.
MOTHER 14. Maiden name: Sarah Williams
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs. Winter Isaacs
Address: North East, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 2 1945 (month) (day) (year)
Cemetery or crematory: Ebenezer
Location: Rising Sun Rural
18. Funeral director: Joseph R. Grant
Address: North East, Md.
19. 10/2 19 45 Lida V. Evans
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28 1945 at 10:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Sept 28 1945 and that I last saw h... alive on Sept 28 1945

Immediate cause of death	DURATION
Malignancy of Intestine	1 yr.
Due to: —	
Due to: —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

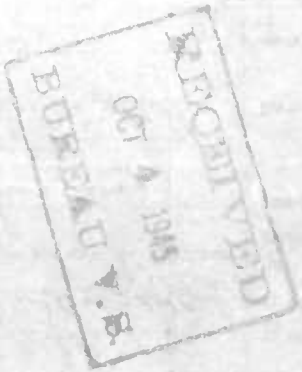
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Jas. J. Greenwald M. D. or other
Address: Elkton Md. Date signed OCT. 2 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
OCT 4 1945
BUREAU V.R.

08937

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:
County: Cecil
City or town: North East
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 Yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: North East
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Franklin Johnson

3.(b) Social Security Number: 218-07-8798

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dora E. Johnson

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Nov. 27-1847

8. AGE: Years: 77 | Months: 10 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Bayview (North East-Md) RD 1
(Town, county, and state)

10. Usual occupation: Retired machanist

11. Industry or business:

FATHER
12. Name: William Johnson
13. Birthplace: North East Md RD 1

MOTHER
14. Maiden name: Elizabeth Jane Trimble
15. Birthplace: North East Md RD 1

16. Informant: Mrs Samuel Ewing
Address: 902 Carrcroft Blvd. Wilmington

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 12 1945 (month) (day) (year)

Cemetery or crematory: R cemetery
Location: Bayview, Md.

18. Funeral director: Joseph R. Grant
Address: North East. Md.

19. 9/12-1945 (Date rec'd by registrar) Lsaie V. Evens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9- 1945, at 10.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9th 1940, to Sept 9- 1945
and that I last saw him alive on Sept 8th 1945

Immediate cause of death	DURATION
Chronic Myocarditis	4 yrs
Due to: General Arteriosclerosis	Unknown
Due to: General Chronic Arteritis	About 2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. H. McKnight M. D. or other
Address: North East. Md. Date signed: 9/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08938

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. RD 5

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Allen Kirk Logan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife: Anna M. Logan

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10 1883

8. AGE: Years 62 | Months 2 | Days 10 | If less than one day: hrs. min.

9. Birthplace: Pleasant Hill Cecil Co. Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: State Road

FATHER 12. Name: Charles Logan

13. Birthplace

MOTHER 14. Maiden name: Theresa Atkinson

15. Birthplace

16. Informant: Mrs Anna M Logan

Address: Elkton RD Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 23 1945 (month) (day) (year)

Cemetery or crematory: Friends

Location: Calvert

18. Funeral director: Joseph R Grant

Address: North East, Md

19. Sept 21 1945 (Date rec'd by registrar) F R Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20 1945 at 6 p.m. 48

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1945 to Sept 20 1945 and that I last saw h... alive on Sept 20 1945

Immediate cause of death	DURATION
Uremia	
Due to: Nephritis - Pneumonia	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dr Lloyd N. Boreley M.D. M. D. or other

Address: Elkton, Md Date signed: Sept 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

08939

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 307 days

Hospital, institution, or street address where death occurred:
Veterans Administration Facility

How long in hospital or institution? 307 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna. County: Allegheny

City or town: Swissvale
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1808 Lafayette St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3. (a) FULL NAME: MAHER, Joseph D.

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

9.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 15, 1890

8. AGE:

Years	Months	Days	If less than one day
55	5	3	____ hrs. ____ min.

9. Birthplace: Roseburg, Pa.
(Town, county, and state)

10. Usual occupation: Coal Miner

11. Industry or business: Mining

FATHER
12. Name: James F. Maher
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Katherine Garrity
15. Birthplace: Pennsylvania

19. Informant: Hospital records
Address: VAF, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept. 19, 1945 (month) (day) (year)

Cemetery or crematory: St. Johns Cemetery,

Location: Geistown, Pa.

19. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. Sept. 19 19 45 (Date rec'd by registrar) Irma E. Daughaday Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18 1945, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 1944, to September 18 1945

and that I last saw him alive on September 18 1945

Immediate cause of death	DURATION
Myocardial Degeneration, due to Lues	over a yr.
Due to: Syphilis of Central Nervous Sys.	over 20 yrs.
Due to:	
Other conditions: Psychosis with Syphilis of Central Nervous System, Meningo-vascular type	over 20 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: ____

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: A. E. Trollinger

A. E. TROLLINGER, LT. COL., M.C., or C.O. DIR.

Address: VAF, Perry Point, Md. Date signed: 9-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170)

CERTIFICATE OF DEATH

08940

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Delaware County:

City or town: Wilmington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 308 Townsend St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Lowred J. Marshall.

3. (b) Social Security Number 221-07-3482.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Married

6.(b) Name of husband or wife: Elmon Marshall

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): Sept 29 1909

8. AGE: Years	Months	Days	If less than one day
36			hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: John Marshall

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Olivia Watson

15. Birthplace: Virginia

16. Informant: J E Thomas

Address: Accomac. Va

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 4 1945 (month) (day) (year)

Cemetery or crematory: Wattsville Cemetery

Location: Wattsville Va

18. Funeral director: J. W. Pippin

Address: Elkton. Md

19. Oct 2 1945 (Date rec'd by registrar) H R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29 1945 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Compound.	
Fracture of skull.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 9/29/45

Where did injury occur? Elkton Rural Cecil Co. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where)? Elk Neck Road.

Means of injury Truck. Injured at work? No.

23. SIGNATURE: R L Dodson M.D. Medical Examiner Cecil County
M. D. or other

Address: Rising Sun Md Date signed 9/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08941

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1640)

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: Union Hosp.
How long in hospital or institution? 2 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton Rural.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: not a veteran

3. (a) FULL NAME: Morris H. McDonald.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Frances McDonald
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): July 18. 1898.

8. AGE: Years	Months	Days	If less than one day
47.	1	16.	..... hrs. ..... min.

9. Birthplace: Lancaster Co Pa.
(Town, county, and state)
10. Usual occupation: Laborer.
11. Industry or business:
FATHER 12. Name: Elmer McDonald.
13. Birthplace: unknown
MOTHER 14. Maiden name: Jennie Patterson
15. Birthplace: unknown.
16. Informant: Frances McDonald.
Address: Elkton Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 6 1945 (month) (day) (year)
Cemetery or crematory: Rosebank
Location: Calvert, Md
18. Funeral director: Joseph R. Evans
Address: North East Md
19. Sept 5 1945 (Date rec'd by registrar) H R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 3 1945 at 5:07 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Bullet wound of brain left side	
Due to (b) Cerebral Hemorrhage.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 9-3-45
Where did injury occur? Elkton Cecil Md
(City or town) (County) (State)
Injured at home, farm, industry, public place, (where?): Home.
Means of injury: Pistol Injured at work?

23. SIGNATURE: H H Dodson MD Medical Examiner or Cecil County
M. D. or other
Address: Rising Sun Md. Date signed 9-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

08942

CERTIFICATE OF DEATH

★ Reg. Diat. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Cambria
City or town: Lilly Rural.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Archibald Joseph McEwan.

3. (b) Social Security Number 190-10-9030

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Hazel M. McEwan
6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Aug 30 - 1876

8. AGE: Years	Months	Days	If less than one day
69		8	hrs. min.

9. Birthplace: Youtsdale, Pa (Town, county, and state)
10. Usual occupation: Coal Miner
11. Industry or business
12. FATHER Name: James McEwan.
13. FATHER Birthplace: Scotland.
14. MOTHER Maiden name: Mary May.
15. MOTHER Birthplace: Scotland
16. Informant: Hazel M. McEwan. Address: 255 Hollingsworth Manor
17. Remove Section Mc Date thereof 10/8/45 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Portage Cemetery
Location: Portage Penn
19. Funeral director: H. C. Pippin
Address: Elkton Md
19. Sept 10 1945 (Date rec'd by registrar) H R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 7 1945 at 10 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Chronic Myocarditis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address: Rising Sun Md. Date signed: 9-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

08943

★ Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Union Elkton Hospital
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 107 Clinton St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lucy Mitchell

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Charles Mitchell
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 8, 1887

8. AGE: Years	Months	Days	If less than one day
58			hrs. min.

9. Birthplace: Elkton, Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: N

MOTHER
14. Maiden name: Eliza Anderson
15. Birthplace: Maryland

16. Informant: Howard Wilson
Address: 107 Clinton St. Elkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 3, 1945 (month) (day) (year)
Cemetery or crematory: Elkton Cemetry Colored
Location: Elkton, Md.

18. Funeral director: Edwin Bell
Address: 909 Poplar St. Wilmg. Del.

19. Oct 3 1945 (Date rec'd by registrar) H Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 22 - 1945, at 4.44 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 1945, to Sept 22 1945 and that I last saw h... alive on Sept 22 - 1945.

Immediate cause of death	DURATION
Cerebral Embolism	1 hr.
Due to: Chronic Myocarditis	2
Due to: Hypertension	2
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jno. J. Russell M. D. or other
Address: Elkton Md. Date signed: Oct 3/45

(M)

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08944

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:

County Cecil

City or town Rising Sun Rural (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Cecil

City or town Rising Sun Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Hannah Rebecca Moore

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Taylor Moore

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Nov. 16. 1865

8. AGE: Years 79 Months 9 Days 19 If less than one day ... hrs. ... min.

9. Birthplace Cecil Co. Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name John F. Pierce

13. Birthplace Ohio

MOTHER 14. Maiden name Catherine Shank

15. Birthplace Penna.

16. Informant Mrs Arthur McCummings

Address Rising Sun Md. R.F.D.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept 9 1945 (month) (day) (year)

Cemetery or crematory Brookview

Location Rising Sun Md.

18. Funeral director J. E. Tyson

Address Rising Sun Md.

19. Sep 7 45 (Date rec'd by registrar) [signature] Registrar

Permit issued 9-9-45

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1945, at 5.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-29 1945, to 9-5 1945

and that I last saw her alive on 9-5 1945

Immediate cause of death	DURATION
Chronic Nephritis	1 year
Due to Arteriosclerotic Kidney	1 year
Due to Hypertension	1 year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David Rothman D.O. M. D. or other

Address Oxford Pa Date signed 9-5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08945

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Cecil Hospital Elkton Md.

How long in hospital or institution? 15 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Rural Near Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Elkton R.D.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Grover L. Myrick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE:

Years	Months	Days	If less than one day
50			hrs. min.

9. Birthplace: Danville Va (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Jean Myrick

13. Birthplace: Va.

MOTHER — 14. Maiden name: Maggie Borner.

15. Birthplace: Va.

16. Informant: Walter Myrick

Address: Danville, Va

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct 1, 1945 (month) (day) (year)

Cemetery or crematory: Danville

Location: Danville, Va

18. Funeral director: H W Lippincott

Address: Elkton Md

19. Oct 1 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25 1945, at 1.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured Pelvis	
Ruptured bladder.	
Due to Crush and fracture	
left leg & internal	
Due to injuries	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 9-27-45

Where did injury occur? External Cecil Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Route 40

Means of injury: Automobile Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County (M. D. or other)

Address: Elkton Md. Date signed: 9-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08946

Reg. Diat. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: North East Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Del. County: New Castle

City or town: Wilmington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1202 Fairview Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Stephen A. Oliva M. D.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Aline Oliva

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): Sept 26. 1907.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
37	11	6.		

9. Birthplace: Brooklyn. N.Y. (Town, county, and state)

10. Usual occupation: Physician

11. Industry or business

FATHER — 12. Name: Frank. Oliva

13. Birthplace: Italy

MOTHER — 14. Maiden name: unknown

15. Birthplace

16. Informant: Aline Oliva

Address: 1202 Fairview Ave Wilmington Del

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 4 1945. (month) (day) (year)

Cemetery or crematory: Brooklyn Cemetery

Location: Brooklyn New York

18. Funeral director: H. W. Pippin

Address: Elkton Md

19. Sept 4 1945 (Date rec'd by registrar) Lida De Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 3 1945 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Drowned.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 9-3-45

Where did injury occur? North East Cecil Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) River

Means of injury Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County

M. D. or other

Address: Rising Sun Md Date signed 9-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08947 95

★ Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Northeastern Rural Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Northeastern R.D. Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: David Jasper Patrick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Margaret C Patrick

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): March 7 1873

8. AGE: Years: 72 | Months: 6 | Days: 11 | If less than one day: ...hrs. ...min.

9. Birthplace: Ash. Lee N.C.
(Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business:

FATHER 12. Name: David Dixon

FATHER 13. Birthplace: Ash. N.C.

MOTHER 14. Maiden name: Clarissa Patrick

MOTHER 15. Birthplace: Ash. Lee N.C.

16. Informant: Raymond C Patrick

Address: Rfnd. RD 2 Pa.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept 21 1945 (month) (day) (year)

Cemetery or crematory: West Nottingham

Location: Colora Md.

19. Funeral director: J. E. Tyson.

Address: Rising Sun Md.

19. Sept 20 1945 (Date rec'd by registrar) Registrar

Permit issued 9-20-45

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 18 1945, at 7 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

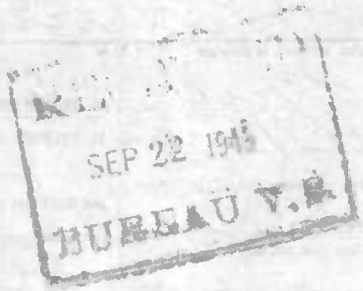
Where did injury occur? ...(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ...Injured at work?

23. SIGNATURE: Medical Examiner for Cecil County
M. D. or other

Address: ...Date signed 9-18-45


SEP 22 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08948

★ Reg. Diat. No. 97

1. PLACE OF DEATH:
County: Cecil.
City or town: Elk Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Elk Mills,
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil.
City or town: Elk Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JAMES WASHINGTON J. W. Pennington

3.(b) Social Security Number 705-09-0233

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Married

6.(b) Name of husband or wife: Jennie Pennington
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): January 16, 1868

8. AGE: Years	Months	Days	If less than one day
77	7	26	....hrs. ....min.

9. Birthplace: Chestnutville, Kent Co., Md
(Town, county, and state)
10. Usual occupation: Retd. R.R.
11. Industry or business
FATHER 12. Name: William Pennington
13. Birthplace: Elkton, Md.
MOTHER 14. Maiden name: Mary Bonnee.
15. Birthplace: No Data
16. Informant: Jennie Pennington
Address: Elk Mills, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 14/45 (month) (day) (year)
Cemetery or crematory: Old Shrewsbury Cemt.
Location: Kent Co. Md
18. Funeral director: H. W. Pippin
Address: Elkton, Md
19. Sept 14 1945 (Date rec'd by registrar) F. R. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 1945, at 12 45 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1945 to Sept. 11 1945 and that I last saw h.im alive on September 5 1945

	DURATION
Immediate cause of death: Myocardial Failure	48 hours
Due to: Acute Coronary Occlusion	June 4
Due to: Cerebral Embolism	July 2
Other conditions: Paralitic, Left	Sept 5

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr. Lloyd H. Sprecher M.D.
M. D. or other
Address: Elkton, Md. Date signed: Sept 11

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2006)

08949

CERTIFICATE OF DEATH

★ Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville - Campbell's Woods
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: —
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 404 N. Paca Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: PORTERA, Philip

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): October 16, 1913

8. AGE: Years	Months	Days	If less than one day
31	11	3	____ hrs. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Produce Merchant
11. Industry or business: Produce

FATHER
12. Name: Tony Portera
13. Birthplace: Unknown

MOTHER
14. Maiden name: Sarah Lizzio
15. Birthplace: Unknown

16. Informant: Hospital Records, Vets. Administration
Address: Perry Point, Md. Oct. 5, 1945

17. Removal & Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 22, 1945 (Month) (Day) (Year)
Cemetery or crematory: New Cathedral
Location: Baltimore Md.

18. Funeral director: ~~LEE A. PATTERSON~~ George L. Schwab
Address: ~~Perryville, Md.~~ 2101 Frederick Ave., Baltimore, Md.

19. Oct. 4 1945 (Date rec'd by registrar) Irma E. Dougherty, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19, 1945, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 13, 1945, to February 4, 1945 and that I last saw him alive on February 4, 1945

Immediate cause of death	DURATION
Decomposed body - cause of death undetermined	7 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: R. L. Dodsonbaker, Medical Examiner, Cecil County
Address: Elkton, Md. M. D. or other
Date signed: 9-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-C)

08950

CERTIFICATE OF DEATH

Reg. Dist. No. 96.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Conowingo Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Cecil
City or town: Conowingo, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Irene M. Ragan

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: S. Taylor Ragan
6.(c) If alive, give age: 46 years
7. Birth date of deceased (mo., day, yr.): May 1, 1900
8. AGE: Years: 45 Months: 4 Days: If less than one day: hrs. min.
9. Birthplace: Port Deposit, Cecil, Md (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business
FATHER 12. Name: George W. Shreve
13. Birthplace: Harford Co., Md
MOTHER 14. Maiden name: Emily K. McKay
15. Birthplace: Cecil Co., Md
16. Informant: S. Taylor Ragan
Address: Conowingo, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4, 1945 (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Cobara, Md. Rural
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Sept 3, 1945 Irene E. Daughaday Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1 - 1945 at 8 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20-45, to August 31 1945
and that I last saw h. alive on Aug 31 - 1945
Immediate cause of death: Chronic Myocarditis — DURATION: 15 yrs
Due to: R. Rheumatic Fever -
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. J. Johnson, M.D.
M. D. or other
Address: Port Deposit, Md. Date signed: 9-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

48951

Reg. Dist. No. 95

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Clay Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Rebecca Carter Richardson

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband ~~or wife~~: Cleveland Richardson

Oct. 4, 1885 — 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 4, 1885

8. AGE: Years: 59 | Months: 11 | Days: 25 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Red Lion, Penn. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Home

FATHER

12. Name: Edward Pierce

13. Birthplace: ~

MOTHER

14. Maiden name: ~

15. Birthplace: ~

16. Informant: Mrs Annie Little

Address: Rising Sun, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 3, 1945 (month) (day) (year)

Cemetery or crematory: Brookview

Location: Rising Sun, Md.

18. Funeral director: Ralph M Reed

Address: Rising Sun, Md.

19. Oct 2 1945 (Date rec'd by registrar) L M Worthington Registrar

Permit issued 10-2-45

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29 1945 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1944 to 9/29 1945 and that I last saw her alive on 9/29 1945

	DURATION
Immediate cause of death: Glomerulo Nephritis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: R L Dodson M.D. M. D. or other

Address: Rising Sun Md Date signed: 10-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

18952

★ Reg. Dist. No. 9/

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Winifred Smith Schaefer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	Widowed

6.(b) Name of husband or wife: Joseph Schaefer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2 1865

8. AGE: Years	Months	Days	If less than one day
80	3	20	hrs. min.

9. Birthplace: Chesapeake City (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER — 12. Name: William Smith

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name:

MOTHER — 15. Birthplace:

18. Informant: Mrs John Maloney

Address: Chesapeake City, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 25/45 (month) (day) (year)

Cemetery or crematory: Chesapeake City Catholic

Location: Chesapeake City, Md

18. Funeral director: H. W. Lapkins

Address: Elkton, Md

19. Sept twenty 24 19 45 (Date rec'd by registrar) Wm. Paul H. Rees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 22 19 45, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 20, to Sept 22 19 45

and that I last saw h[illegible] alive on Sept 21 19 45

Immediate cause of death	DURATION
Chronic Endocarditis	
Due to	
Due to	
Other conditions Arteriosclerosis General	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Herbert Baker M.D. (M. D. or other)

Address: Elkton Md Date signed: 9/22/45


RECEIVED
SEP 26
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 86

CERTIFICATE OF DEATH

Reg. Dist. No. 1895 96

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Linda Anne Snelling

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 1, 1945

8. AGE: Years | Months 2 | Days 25 | If less than one day ____ hrs. ____ min.

9. Birthplace: Port Deposit Cecil Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: [illegible] Snelling
13. Birthplace: Stafford Co., Va.

MOTHER
14. Maiden name: Ella Mae Hammell
15. Birthplace: Cecil Co., Md.

16. Informant: Ella Snelling
Address: Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 28, 1945 (month) (day) (year)

Cemetery or crematory: Harmony Church

Location: Liberty Stone Md. Rural

18. Funeral director: Ed A. Patterson & Son

Address: Perryville, Md.

19. Sept 28 1945 (Date rec'd by registrar) James E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 1945, at 7.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945 to Sept. 26 1945.
and that I last saw h.er alive on Sept. 26. 1945.

	DURATION
Immediate cause of death: Convulsions	1 day
Due to: malnutrition.	2 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. J. Bruson M.D.
M. D. or other

Address: Port Deposit Date signed 9-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

08954

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Berks
City or town: Reading Berks.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Philadelphia
City or town: Philadelphia
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1621 N. 29 St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Rose Spencer.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widow

6.(b) Name of husband or wife: Charles Spencer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 13 - 1886

8. AGE: Years	Months	Days	If less than one day
58	Oct	13	hrs. min.

9. Birthplace: Reading Pa.
(Town, county, and state)
10. Usual occupation: H.W.
11. Industry or business:

FATHER
12. Name: Thomas Hoban
13. Birthplace: Reading Pa

MOTHER
14. Maiden name: Boginski
15. Birthplace: Reading Pa.

16. Informant: Gene F. Spencer
Address: Rising Sun Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 26, 1945 (month) (day) (year)
Cemetery or crematory: Bethsemane
Location: Reading, Berks Co., Pa.
18. Funeral director: Geo. A. Patterson & Son
Address: Perryville, Md.

19. Sept. 24 (Date rec'd by registrar) 1945 Irene E. Dougherty. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21 19 45 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/20 19 45, to 9/21 19 45
and that I last saw h[illegible] alive on 9/20 19

Immediate cause of death	DURATION
Acute Coronary Thrombosis.	
Due to Myocarditis & Rheumatic	
Due to Chronic Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. H. Dodson MD M. D. or other
Address: Reading Pa Date signed: 9/21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (114d)

CERTIFICATE OF DEATH

08955

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs. 5 mo. 2 da.
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Frederick
City or town: Winchester
(If outside city or town limits, write RURAL and give nearest town)
Street No. 321 S. Loudoun St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: SPRINT, Frank H.

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): May 15, 1887

8. AGE: Years	Months	Days	If less than one day
58	4	13	- hrs. - min.

9. Birthplace: Boyce, Va. (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: -

FATHER
12. Name: Thomas Sprint
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mamie R. Hunston
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 9-29-45 (month) (day) (year)
Cemetery or crematory: Mt. Hebron
Location: Winchester, Va.
18. Funeral director: Pennington & Son
Address: Pennington & Son, Havre De Grace, Md.

19. Sept. 29 1945 (Date rec'd by registrar) Irma E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 28 1945, at 11:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1932, to Sept. 28 1945 and that I last saw him alive on September 28 1945

Immediate cause of death	DURATION
Dementia Precox, Hebephrenic Type	13 yrs.
Due to	
Due to	
Other conditions: Abscess of Lung	Undetermined
Arteriosclerosis, generalized	"

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op.: -
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: A.E. Trollinger
A.E. TROLLINGER, Lt. Col. M.C. Clr. Direc.
Address: Veterans Administration, Perry Point, Md. Date signed: 9-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

448956 Elmore

★ Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Principio Furnace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Principio Furnace, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nancy R. Swackhammer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Lewis E. Swackhammer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 2, 1876

8. AGE:

Years	Months	Days	If less than one day
69	7	25	..... hrs. ..... min.

9. Birthplace: Jeddo St Clair Mich. (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business
FATHER 12. Name: William Statts
13. Birthplace: Canada
MOTHER 14. Maiden name: Maryanne Sinclair
15. Birthplace: England
16. Informant: Lewis E Swackhammer
Address: Principio Furnace, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 29 1945 (month) (day) (year)
Cemetery or crematory: St. Marks
Location: Aikin, Md. Rural
18. Funeral director: New & Patterson & Son
Address: Perryville, Md.
19. Sept. 29 1945 (Date rec'd by registrar) Irma E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27 1945 at 11:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16 1945, to Sept 27 1945
and that I last saw h... alive on ... September ... 1945

Immediate cause of death	DURATION
Carcinoma of Liver	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L. W. Benson M.D.
M. D. or other
Address: Port Deposit, Md. Date signed: 9/28/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age

is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57E)

CERTIFICATE OF DEATH

118957

Reg. Dist. No. 91

1. PLACE OF DEATH:

County Cecil

City or town Chesapeake City Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Townsend Harvey Walter

3.(b) Social Security Number

4. Sex M. | 5. Color or race Wh | 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mary E Walter

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) May 22 1878

8. AGE: Years 67 Months 3 Days 28 If less than one day ....hrs. ....min.

9. Birthplace Oil Run Pa (Town, county, and state)

10. Usual occupation Retd

11. Industry or business

FATHER 12. Name William Harvey Walter

13. Birthplace Pa

MOTHER 14. Maiden name Rosanna Kirk

15. Birthplace Pa

16. Informant Mrs Mary E Walter

Address Chesapeake City, Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept 23/45 (month) (day) (year)

Cemetery or crematory Bethel

Location Nr Chesapeake City, Md

18. Funeral director H W. Pippin

Address Elkton Md

19 September 23 1945 (Date rec'd by registrar) Mrs Ralph H. Reed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1945, at 2 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1936, to Sept 21 1945

and that I last saw him alive on September 1945

Immediate cause of death Chronic arthritis — DURATION 10 years

Due to

Due to

Other conditions Paralysis of oesophagus — 1 week

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry S Davis MD — M. D. or other

Address Chesapeake City Md Date signed 9/21/45

08958

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (140-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 92

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred: Union Hospital 7 days
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: W. Va. County: McDowell
City or town: Mohegan (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ruth Ward
3. (b) Social Security Number:

4. Sex: F.
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Feb. 13 1926
8. AGE: Years 19, Months 6, Days 10. If less than one day ... hrs. ... min.
9. Birthplace: War. W. Va. (Town, county, and state)
10. Usual occupation: Lab at hospi
11. Industry or business
FATHER 12. Name: John Ward
FATHER 13. Birthplace: Martin Co. Ky.
MOTHER 14. Maiden name: Millie Steel
MOTHER 15. Birthplace: Lawrence Co Ky.
16. Informant: Millie Ward
Address: Mohegan W. Va.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 12 1945 (month) (day) (year)
Cemetery or crematory: Welch cemetery
Location: Welch W Virginia
18. Funeral director: H W Pippin
Address: Elkton Md
19. Sept 12 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11 1945, at 8:55 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Septic Peritonitis due to perforation	
Due to: of uterus produced by foreign body	
Due to: for purpose of abortion.	
Other conditions: about 3 mo gestation	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: R. L. Dodson, M. D. or other — Medical Examiner for Cecil County
Address: Rising Sun Md. Date signed: 9-11-45